

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005009</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLARK MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1220 MISSOURI AVE JEFFERSONVILLE, IN 47130</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Facility Number: 005009</p> <p>Complaint #: IN00120928</p> <p>Unsubstantiated: Lack of substantial evidence.</p> <p>Dates: 2-5-13</p> <p>Surveyor: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Clark Memorial Hospital was found in compliance with 410 IAC 15-1.6.8, Surgical services, 410 IAC 15-1.5-1, Dietary services, and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 02/08/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1